Executive Office of Health and Human Services

Workers' Compensation
And
Employment Safety

Industrial Accident Report

The Executive Office of Health and Human Services in collaboration with the Human Resources Division has a zero tolerance for workers' compensation fraud.

Section I – To be completed within 24 hours of injury

Form	Instructions
EOHHS Industrial Accident Report (Pages 1 – 4)	**Supervisor** of injured employee is responsible for completing the Industrial Accident Report with the **employee**. **Manager** completes Manager review Section of Page 4.
Witness Report (Pages 5 -6)	**Supervisor** of injured employee provides to employee(s) who witness incident.
Concurrent Employee Review Form (7)	Employee completes and signs.
Medical Release Form (8)	Employee completes and signs.

Next Steps:

1) Supervisor reviews entire packet for completion, legibility, accuracy of dates, and required signatures.

2) The entire packet must be then immediately given to the Program/ Lab Manager for their review and completion of Page 4, Manager's Review.

3) The entire packet must be hand-carried to Carol Cormier, SLI Human Resources **within 24 hours** of the accident for processing. Carol's back-up is Cecilia Marinucci (see contact information below)

Section II –Detach and give entire section to the employee. Supervisor explains to the employee the importance of the attachments.

Physician's Report	Employee brings to treating Physician. Physician report must be completed for each visit. Completed form may be faxed Canton number listed below.
Injured Guide to Medical Treatment	Information only. No action needed

Contact Information

Department of Public Health State Laboratory Institute Human Resources Office 305 South St. Room 203B Jamaica Plain, MA 02130	**The Office of Health and Human Services** Human Resources Office Benefits and Leave Division 3 Randolph Street Canton, MA 02021
Contact: Carol Cormier Phone: 617- 983- 6206 Fax: 617-983-6256	Contact: Cecilia Marinucci Phone: 781-830-8313 Fax: 617-830-8361

SECTION I:

TO BE COMPLETED BY THE SUPERVISOR WITH THE EMPLOYEE

(Do **not** give this to the employee to take home)

Executive Office of Health and Human Services
Industrial Accident Report

Complete and Return to:
Benefits and Leave Coordinator
in the Human Resources Office
within 24 hours

EOHHS - Industrial Accident Report

The supervisor must discuss the incident with the employee and obtain very specific details of the incident for example:

- were there any witnesses
- was the employee unconscious at any point
- was there any bruising, lacerations, redness, swelling noted

Date of Injury: _____ Today's Date: _____

Department: _____

Print Name: _____
(First) (Middle) (Last)

Sex: ☐ Male ☐ Female Employee ID#: _____ Record#: _____

Address: _____ City: _____ State: _____ Zip:_____

Home Telephone: _____ Cell Phone: _____

Unit: _____

State Hire Date: _____ Department Hire Date: _____

Status: ☐ Full Time Employee ☐ Part Time Employee Work Hours/Wk: _____

Shift: ☐ 1st ☐ 2nd ☐ 3rd Number of Days Off: _____

Occupation (Official Position Title): _____

Functional Title: _____

Injury Time: _____ ☐ AM ☐ PM Date Reported: _____

Do you have another job? ☐ Yes ☐ No (If Yes, complete and sign page 7, if No, just sign page 7)

EOHHS - Industrial Accident Report

Describe how the injury occurred. Give SPECIFIC details/observations:

I hereby swear *under the pains and penalties of perjury* that the above statements are true and complete to the best of my knowledge.

Print name of person completing this page: _____

_____ _____ _____

(Signature) (Title) (Date)

EOHHS - Industrial Accident Report

Body Part Injured: _____

Injury Type: _____
i.e. Bruise, cut, burn, bite, sprain/strain, scratch/abrasion, dislocation

Select One or More Injury Categories:

☐ Fall	☐ Lifting	☐ MVA (Motor Vehicle Accident)	☐ Assault
☐ Exposure	☐ Repetitive Use	☐ Equipment	☐ Moving/Walking
☐ Stress/Heart Attack	☐ Burn	☐ Cut	☐ Restraint
☐ Other explain:			

_____

Severity of Injury:

___(1)Minor injury; no likely lost time; no likely medical bills
___(2)Small injury; no likely lost time; possible medical bills
___(3)Moderate injury; possible lost time; probable medical bills
___(4)Significant injury; probably 0 to 5 days of lost time and medical bills
___(5)Severe injury; probably 5 plus days lost time and medical bills

Where The Injury Occurred:

Building: _____

Injury Location: _____
(Floor) (Room number)

Was the incident the result of a violent act? ☐ Yes ☐ No

Was the claimant engaging in usual job activities? ☐ Yes ☐ No

If no, explain:_____

_____

Injury reported to:_____
(Please Print Name)

Was the incident witnessed? ☐ Yes ☐ No

If yes, provide the names of witnesses and ask that each complete a Witness Report (page 5 & 6)

Witness: Name_____ Title_____Tel_____

Name_____ Title_____Tel_____

EOHHS - Industrial Accident Report

Supervisor's Review: Are you satisfied that the injury occurred as stated? ☐ Yes ☐ No

If no, explain: _____

_____

Did the employee leave work? ☐ Yes ☐ No Time: _____ ☐ AM ☐ PM

Did the claimant seek medical attention? ☐ Yes ☐ No

If so, where? _____

Is claimant a disabled veteran or has any other known disability? ☐ Yes ☐ No ☐ Unknown

Do you feel the claimant would benefit from any referral to Rehabilitation? ☐ Yes ☐ No ☐ Unknown

Do you feel the claim warrants further investigation? ☐ Yes ☐ No

Did the employee request time off during or near the date of injury? ☐ Yes ☐ No

Is there any disciplinary action pending on this employee? ☐ Yes ☐ No

Please attach any information you feel would be useful to HRD/WC Section in managing this claim.

I hereby swear *under the pains and penalties of perjury* that the above statements are true and complete to the best of my knowledge.

Supervisor: _____ _____ Date:_____
Print Name: Sign Name:

Manager's Review: Are you satisfied that the injury occurred as stated? ☐ Yes ☐ No

If no, explain:_____

_____

_____

I hereby swear *under the pains and penalties of perjury* that the above statements are true and complete to the best of my knowledge.

Manager: _____ _____ Date:_____
Print Name: Sign Name:

EOHHS – Industrial Accident Report

WITNESS REPORT

Name of Injured Employee: _____ Accident Date: _____

Accident Location: _____ Accident Time: _____ ☐ AM ☐ PM

Witness Name (Please Print): _____

Witness Address: _____
Street Apt # / Box #

_____
City / Town State Zip Code

Witness Home Telephone #: (_____) _____ - _____ Work Number: _____

Were you ***PRESENT*** at the incident? _____ YES _____ NO

Did you ***SEE*** the incident occur? _____ YES _____ NO

WHAT HAPPENED? (Give SPECIFIC details of what you observed.)

_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

Are you related to the employee? _____ YES _____ NO
If YES, what is the relationship? _____

I hereby swear *under the pains and penalties of perjury* that the above statements are true and complete to the best of my knowledge.

_____ _____
Witness Signature Date

EOHHS – Industrial Accident Report

WITNESS REPORT

Name of Injured Employee: _____ Accident Date: _____

Accident Location: _____ Accident Time: _____ ☐ AM ☐ PM

Witness Name (Please Print): _____

Witness Address: _____
Street Apt # / Box #

_____
City / Town State Zip Code

Witness Home Telephone #: (_____) _____ - _____ Work Number: _____

Were you ***PRESENT*** at the incident? _____ YES _____ NO

Did you ***SEE*** the incident occur? _____ YES _____ NO

WHAT HAPPENED? (Give SPECIFIC details of what you observed.)

_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

Are you related to the employee? _____ YES _____ NO
If YES, what is the relationship? _____

I hereby swear *under the pains and penalties of perjury* that the above statements are true and complete to the best of my knowledge.

_____ _____
Witness Signature Date

Commonwealth of Massachusetts
Human Resources Division

Workers' Compensation Section
One Ashburton Place, 3rd Floor
Boston, MA 02108

CONCURRENT EMPLOYMENT REVIEW FORM

CLAIMANT'S NAME: _____ SS#_____
STATE AGENCY: _____
DATE OF INJURY: _____

OTHER EMPLOYER NAME: (public or private)_____
EMPLOYER ADDRESS:_____
CONTACT PERSON: _____Telephone #_____

DATES OF OTHER EMPLOYMENT: From_____ To_____
DO YOU EXPECT THIS EMPLOYMENT TO CONTINUE? Yes_____ No_____

JOB DESCRIPTION OF OTHER EMPLOYMENT: _____
_____
_____
_____

Please list all positions both private and public other than the position for which you are claiming workers' compensation. Attach a separate sheet for each position.

Week No.	Year: Week Ending Month Day	Gross Amount Paid including overtime
1		
2		
3		
4		
5		
6		
7		
8		
9		
10		
11		
12		
13		
14		
15		
16		
17		

Week No.	Year: Week Ending Month Day	Gross Amount Paid including overtime
18		
19		
20		
21		
22		
23		
24		
25		
26		
27		
28		
29		
30		
31		
32		
33		
34		

Week No.	Year: Week Ending Month Day	Gross Amount Paid including overtime
35		
36		
37		
38		
39		
40		
41		
42		
43		
44		
45		
46		
47		
48		
49		
50		
51		
52		

I hereby certify that the above information is a complete and accurate statement of income from any other employment. Signed under the pains and penalties of perjury.

_____ _____
Claimant's Signature (Employee's Signature) *Date*

This statement of income is to be utilized to determine the amount of workers' compensation you may receive for the injury for which you have a claim.

Commonwealth of Massachusetts
Human Resources Division

Workers' Compensation Section
One Ashburton Place, 3rd Floor
Boston, MA 02108

AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS

CLAIMANT'S NAME: _____

SOCIAL SECURITY #: _____-_____-_____

ADDRESS: _____

_____

TELEPHONE NUMBER: _____

EMPLOYING AGENCY AND LOCATION: _____

_____

DATE OF INJURY: _____

I am filing a claim for workers' compensation benefits and hereby authorize any hospital or other medical provider to release to the Human Resources Division (HRD), Workers' Compensation Section, ***any and all information relative to my claim for benefits, including, but not limited to, psychiatric records, records pertaining to HIV (AIDS) or other records especially those protected by law.*** I understand that HRD may share this information with my employer, medical and or vocational rehabilitation consultants, utilization review consultants, physicians and other medical care providers and other state agencies involved in the workers' compensation process and I hereby authorize such release to the other persons and entities described.

SIGNATURE: _____ DATE: _____

PLEASE COMPLETE THIS AUTHORIZATION AND RETURN TO:

Human Resources Division
Workers' Compensation Section
One Ashburton Place, 3rd Fl.
Boston, MA 02108

SECTION II:

TO BE GIVEN TO THE EMPLOYEE

Industrial Accident Instructions for Employees

1. To ensure you follow the proper procedures, it is your responsibility to read the attached **Injured Workers' Guide to Medical Treatment** regarding the Human Resources Division, Workers' Compensation policy.

2. You must sign the **Concurrent Employment Review Form** and the **Authorization for Release of Medical Records.** (These forms were in the original industrial accident report that your supervisor completed with you.)

3. If outside medical treatment is necessary, you must give the attached **Physician Report** to the treating physician to complete. **Once completed, the report MUST be returned (or faxed) to the Benefits and Leave Representative immediately.**

4. If medical attention is needed, you have the option to use your own medical provider or make arrangements through the medical provider associated with your Agency. If you require transportation your supervisor can assist in making arrangements.

5. After treatment, you should return to work. If you are unable to return to work; **YOU MUST CALL YOUR SUPERVISOR IMMEDIATELY TO NOTIFY THEM OF YOUR WORK STATUS.**

6. Communication between **you**, your **Employer** and the **Workers' Compensation Manager** is essential in properly managing your industrial accident claim. You must submit all subsequent medical documentation to the Benefits and Leave Coordinator.

Commonwealth of Massachusetts
Human Resources Division

Workers' Compensation Section
One Ashburton Place, 3rd Floor
Boston, MA 02108
PHYSICIAN'S REPORT

Report status: Initial_____Follow-up _____

TO BE COMPLETED BY EMPLOYER:

1. Name of Facility/Agency Department of Public Health – State Lab ____phone (781)830-8313
   Address: 305 South Street Jamaica Plain MA 02130_____
   Name/Title of Workers' Compensation Contact: Cecilia Marinucci, Benefits and Leave Coordinator

TO BE COMPLETED BY EMPLOYEE:

2. Full Name _____Date of Birth: ___/___/___
   First Middle Last
   Address:_____
3. Date of Injury: _____Social Security No.: _____-_____-_____
4. Has employee received prior medical treatment for this injury? Yes_____ No_____
   If yes, by whom?_____

TO BE COMPLETED BY MEDICAL PROVIDER/OFFICE STAFF:

5. Practice Name: _____
6. Physician Name (print or type): _____ Date of Exam____/___/____
   License No.:_____Specialty:_____Date of Report___/___/____
7. Mailing Address: _____
8. Phone Number: (_____)-_____ Fax Number: (_____)-_____

TO BE COMPLETED BY PHYSICIAN (MEDICAL EXAMINATION RESULTS):

9. Provide patient's statement as to how the injury occurred: _____
   _____
10. Is there a history/evidence of pre-existing injury/disease: Yes _____ No_____
    If yes, explain:_____
11. Subjective Complaints: _____
    _____
12. Objective Findings: _____
    _____
13. Neurological Findings (if any): _____
    _____
14. Diagnosis:_____
15. Plan of Treatment:_____
16. In your opinion, was the accident/exposure a producing/contributing cause of the injury? Yes___ No____
17. Is the employee able to perform his/her regular work duties? Yes____ No____
    If no, employee may return to full duty in _____days/weeks. (Circle one)

18. ***FUNCTIONAL LIMITATIONS***:
    Temporary modified work may be available at state facilities. The employer may develop a modified job based on any restrictions described below. Patient ***CANNOT:***

SIT	more than _____hours/day
STAND/WALK	more than _____hours/day
CARRY/LIFT	more than ___10____20___30___40___50___lbs.
PUSH	more than ___10____20___30___40___50 ___lbs.
PULL	more than___ 10____20___30___40___50 ___lbs.
DRIVE VEHICLE	Yes_____ No_____
OTHER (please describe):	_____

19. (Physician Referrals Only) Indicate Physician: _____Specialty: _____

SIGNATURE OF PHYSICIAN

I certify under the pains and penalty of perjury that I have personally examined the above named employee.
Signature:_____Date:_____
(I am a duly licensed physician)

THE COMMONWEALTH OF MASSACHUSETTS
EXECUTIVE OFFICE FOR ADMINISTRATION AND FINANCE
HUMAN RESOURCES DIVISION/WORKERS' COMPENSATION SECTION
ONE ASHBURTON PLACE, BOSTON, MA 02108
(617) 727-3437/ (800) 266-7991/ Fax: (617) 727-7816

DEVAL L. PATRICK
Governor

LESLEY A. KIRWAN
Secretary

TIMOTHY P. MURRAY
Lieutenant Governor

Injured Workers' Guide to Medical Treatment

The Human Resources Division (HRD) Worker's Compensation Section is the insurer as well as the Utilization Review agent for your industrial accident. Your agency's workers' compensation agent will provide you with HRD/WCS Notice of Injury Packet. Please make sure that your agencies workers' compensation designee has completed the entire packet and has advised HRD of your claim. Upon receipt of your claim, the Human Resources Division/Workers' Compensation Section will assign a file number. If you have any questions regarding your claim, you may call the HRD claim's unit at 1-617-727-3437 and ask to speak with the adjuster for your employing agency.

The Division of Industrial Accidents (DIA) requires all workers' compensation insurers to perform utilization review to determine the medical necessity of health care services. You or your medical provider must contact HRD each time you seek treatment for your work-related injury. You may contact the Utilization Review department once a claim has been filed at 1-800-266-7991 or by fax at 617-727-7816.

Please notify your medical provider of the insurance address listed on the top of this page. **Under no circumstances should you provide your employing agency as the insurer.**

The Division of Health Care Finance and Policy (DHCFP) has statutory authority under Massachusetts General Laws of the Commonwealth (M.G.L.) c152s.13 and c118 G to regulate rates of payment for hospitals, health care providers and prescription drugs covered by insurer and other purchasers under M.G.L. c.152, the Worker's Compensation Act.

The rates of payment provided by HRD will be consistent with the fee schedule established by the DHCFP. Reimbursement for health care services is considered payment in full; your provider may not bill you in excess of the established rate of reimbursement. **Please inform your medical provider, that in order to be considered for reimbursement, all bills must be received on a HICFA 1500 or UB 90 form with a detailed description of the services rendered attached.**

Reimbursement for prescription drugs is also consistent with the fee schedule; HRD does not reimburse for co-payments resulting from the use of another insurance policy. As of January 2003, area pharmacies that will bill HRD for pharmacy charges include Brooks, Walgreen's, and Wal-Mart.